Section 2

Home and Community-based Waiver Services (HCBWS) for Technology Dependent, Medically Fragile Individuals

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1 GENERAL POLICY

Section 1915 (c) of the Social Security Act permits States to offer, under a waiver of statutory requirements, Medicaid funded home and community-based waiver services to eligible clients as an alternative to institutional care. Utah's Medicaid waiver provides home and community-based waiver services to technology dependent, medically fragile individuals under the age of 21 who would otherwise require care in a nursing facility. Waiver services may continue to be provided to clients over the age of 21 if the client entered the waive prior to his or her 21st birthday and the client continues to meet the medical criteria for waiver services.

The waiver was approved effective January 1, 1995 for a three year period and may be renewed for intervals of five years.

Utah's home and community-based services waiver includes a waiver of "comparability" requirements under section 1902(a)(10)(B) of the Social Security Act. This allows the State to provide Medicaid reimbursed home and community-based services to a limited number of technology dependent, medically fragile individuals. The State is also permitted to waive certain income and resource rules found in Section 1902(a)(10)(c)(I)(III) of the Act when determining eligibility for the waiver.

1 - 1 Purpose

Medical technology makes it possible to enhance the lives of medically fragile clients with special needs. Historically, many families have found it necessary to place a medically fragile individual in an institutional setting in order to obtain needed services and supports. Utah's home and community-based waiver program is designed to offer clients and their families an option to premature or unnecessary institutionalization. Under the waiver, eligible clients who would otherwise require a level of care provided in a nursing facility may instead be offered the choice to receive appropriate care and services at home and in their community. Waiver clients are eligible to receive an array of non-institutional, home and community-based services **in addition to** traditional medical services covered by Medicaid and other insurers.

1 - 2 Waiver Administration

The waiver is administered by the Department of Health, the Division of Health Care Financing and the Division of Community and Family Health Services.

A. Division of Health Care Financing: Administrative Authority and Responsibilities

The Division of Health Care Financing is the single State agency responsible to administer and supervise the administration of the Utah Medicaid program including waiver programs. State funds appropriated to the Division of Health Care Financing by the Utah legislature are used to match Federal Medicaid funds received under Utah's waiver for technology dependent, medically fragile clients.

The Division of Health Care Financing maintains final administrative oversight and authority for the waiver as it currently exists or is hereafter amended.

B. Division of Community and Family Health Services: Administrative Authority and Responsibilities

The Division of Community and Family Health Services, Children's Special Health Care Services, is the State's Maternal and Child Health, Title V designee which has the statutory responsibility to provide services to clients with special health care needs.

In accordance with the approved waiver, Division of Community and Family Health Services oversees the day-to-day operation of the waiver.

1 - 3 Definitions

For purposes of the Home and Community-based Waiver for Technology Dependent, Medically Fragile Individuals, the following definitions apply:

Applicant: A child who has applied for services under the waiver, but who has not yet been determined eligible, or not yet received approval, for services under the Home and Community-based Waiver for Technology Dependent, Medically Fragile Individuals waiver.

Case Manager: See 'Waiver Case Manager'.

Child: An individual under the age of 21.

Medicaid Eligibility Worker: A qualified employee of the Division of Health Care Financing who determines eligibility for Medicaid.

Plan of Care: The plan of care is written by the waiver case manager to describe services needed by the client and submitted for approval to Medicaid.

Prior Authorization: Authorization received BEFORE services are provided.

Recipient: A client who qualifies for and receives services under the waiver.

Waiver or Waiver services: The Home and Community-Based Waiver for Technology Dependent, Medically Fragile Individuals and services covered under the waiver.

Waiver Case Manager: A qualified employee or contractor of the Division of Community and Family Health Services who provides case management services under the Home and Community-based Waiver for Technology Dependent, Medically Fragile Individuals.

2 SERVICE AVAILABILITY

Home and community-based waiver services for technology dependent, medically fragile individuals are covered benefits only when provided in accordance with the four criteria listed below.

A. To clients eligible for the waiver and residing in the State of Utah;

B. To clients who are not inpatients of a hospital, nursing facility, or Intermediate Care Facility for the Mentally Retarded.

C. Pursuant to a written plan of care approved by Medicaid;

D. Through a qualified, enrolled Medicaid provider as described in Chapter 3, SCOPE OF SERVICE.

Details concerning the eligibility process and these four criteria are explained in the remainder of this chapter.

2 - 1 Eligible Clients

A. To be eligible for services under this waiver, the technology dependent, medically fragile individual must meet all five of the following "targeting criteria":
   ~~1. Be under the age of 21;~~
   1. Be under the age of 21 at the time he or she is approved for the waiver;

   2. Qualify for Medicaid based on his or her income and resources;

   3. Have at least two care givers trained (or willing to be trained) and available to provide care, and be cared for in a home that is safe and can accommodate the necessary medical equipment and personnel needed;

   4. Meet admission criteria for Nursing Facility care; **and**

   5. Require, in accordance with written orders of a physician, skilled nursing or skilled rehabilitation services (or a combination of both) at least five days per week. The services ordered must be, singly or in the aggregate, so inherently complex that they can be safely and effectively performed only by, or under the supervision of, professional or technical personnel. For purposes of this waiver, the inherent complexity of services is evidenced by the individual's dependence on one or more of the following:

      a. Daily dependence on a mechanical ventilator;

      b. Daily dependence on tracheostomy-based respiratory support;

      c. Daily dependence on continuous positive airway pressure (C-PAP);

d. Dependence within the past six months on tracheostomy-based respiratory support and current need for one or more of the following skilled services at least five times per week:

(1) nursing
(2) physical therapy
(3) occupational therapy
(4) speech therapy
(5) tube feeding;

e. Dependence on intravenous administration of nutritional substances or medications through a central line, which the physician anticipates will be necessary for a period of at least six months.

B. A client's eligibility for benefits and services under this waiver will continue as long as he or she meets the criteria for nursing facility level of care.

2 - 2 Access to Waiver

The first point of contact for all waiver services is the Division of Community and Family Health Services waiver case manager. Prior to an applicant receiving waiver services, the case manager must:

A. Certify that the applicant meets the level of care requirements, and that there are feasible alternatives available under the waiver;

B. Ensure the applicant has been determined eligible for Medicaid; and

C. Offer the eligible applicant the choice of waiver services or nursing facility services.

2 - 3 Level of Care Determination (Certification)

A. The waiver case manager, through consultation with other health professionals and with the assistance of the applicant and/or the applicant's legal representative, will obtain physician's orders, medical records and pertinent interdisciplinary evaluations needed to thoroughly evaluate the applicant's clinical condition.

B. An applicant meets the level of care criteria when documentation supports the following:

1. The applicant's condition meets the targeting criteria defined in Chapter 2 - 1, *Eligible Clients*;

2. There is a reasonable indication that the applicant might need the level of care provided in a nursing facility in the near future (that is a month or less) unless he or she receives home or community-based services; and

3. The applicant's needs can be appropriately and cost effectively met in the community. For example, there are feasible alternatives available under the waiver.

C. Applicants who **do not meet** the waiver level of care criteria will receive written notice from the case manager specifying the reason(s) for ineligibility, and the applicant's rights to request a hearing. Hearing rights are described in Chapter 2 - 10.

D. To support the level of care determination, the following documentation must be included in the applicant's case management record:

1. Copy of physician's orders, applicant's medical records and other pertinent evaluations obtained to conduct

the level of care evaluation;

2. A Waiver Level of Care Evaluation Form (three pages) completed by the case manager; and

3. A completed Case Management Assessment Form.

2 - 4 Medicaid Eligibility Determination

A. Once an applicant has been certified by the case manager to meet the waiver targeting and level of care criteria specified in Chapters 2 - 1 and 2 - 3, he or she will be referred to the Division of Health Care Financing, Bureau of Eligibility Services, for a determination of Medicaid eligibility.

B. The Medicaid eligibility worker will coordinate with the waiver case manager to obtain all necessary documentation to complete the Medicaid application. The eligibility worker will notify the waiver case manager of the Medicaid eligibility determination.

2 - 5 Client Freedom of Choice

A. Once an applicant has been certified by the case manager to meet the level of care criteria for the waiver and the eligibility worker has determined the client meets Medicaid eligibility requirements, the applicant or his or her legal representative must be:

1. informed by the case manager of feasible alternatives under the waiver;

2. advised if there is a waiting list for admission to waiver services (Refer to Chapter 2 - 6, *Limit on Number of Waiver Clients (Waiting List)*; and

3. offered the choice of nursing facility or home and community-based waiver services.

B. If the eligible applicant chooses nursing facility services, the waiver case manager will provide the applicant with information and assistance to access such facilities.

C. If the applicant chooses home and community-based waiver services and there is not a waiting list, the waiver case manager will notify the eligibility office to open the case and the effective date of waiver services. The applicant will then be given the opportunity to choose the provider(s) of waiver services if more than one qualified provider is available to render the services.

D. The waiver case manager and the applicant or legal representative must document the applicant's decision by completing Sections 1 and 2 of the Division of Community and Family Health Services Freedom of Choice form.

2 - 6 Limit on Number of Waiver Clients (Waiting List)

The number of clients who may be served each year through the home and community-based waiver program is limited. When the number of eligible applicants for this waiver exceeds the number of clients approved by the Federal Health Care Financing Administration for the waiver (calendar) year, a waiting list will be established.

A. To be included on the waiting list, an applicant must first be determined eligible for waiver services.

B. Each applicant on the waiting list will be assigned a numerical ranking by the waiver case manager. The case manager calculates the numerical ranking by reviewing the applicant's assessment information, identifying the targeting condition(s) which make the applicant eligible for the waiver, and assigning one or more of the numerical weighting factor(s) listed below for each targeted condition identified.

TARGETING CONDITION	WEIGHT FACTOR
Ventilator Dependent	10
Trach Dependent	8
C-Pap Dependent	6
Post-Trach	4
Central Line Dependent	2

C. Priority for admission to the waiver from the waiting list will be given to the applicant with the highest total numerical score. If more than one applicant has the same (highest) score, length of time on the waiting list will be used to determine who is selected.

D. The case managers are responsible for managing and maintaining the waiting list.

2 - 7 Plan of Care

All waiver services are furnished pursuant to a written plan of care. Medicaid reimbursement is **not** available for services provided prior to the development of the plan of care.

The plan of care describes all of the services that the applicant needs, including waiver services and non-waiver services. The plan of care must include medical and other services to be furnished to the applicant, their frequency, and the type of provider who will furnish each service.

The waiver case manager is responsible for the development of the plan of care.

A. Prior Authorization of Plan of Care

The plan of care for the applicant is subject to approval by Medicaid. Before an applicant is admitted to waiver services, the waiver case manager must submit the following to the Medicaid Prior Authorization Unit:

1. documentation of the most recent level of care evaluation;
2. current assessment documentation which supports the requested services; and
3. a written, signed plan of care containing at least the following information:
    a. the applicant's name and Medicaid Identification number;
    b. the services to be provided to the applicant;
    c. the provider of each service reimbursable by Medicaid and the provider's Medicaid number;
    d. Medicaid procedure codes and the number of units being requested for each service; and
    e. beginning and ending dates for proposed services.

Medicaid Prior Authorization staff will send a written notice of decision to the waiver case manager who, in turn, will provide written notice to providers and the applicant.

B. Periodic Review of the Plan of Care

Once the plan of care has been approved, and the client becomes a recipient of waiver services, the plan of care should be reviewed as frequently as necessary to ensure it meets the needs of the client. A formal review of the plan is required at least every four months and must be completed during the calendar month in which it is due.

Should the client experience a significant change in health, the plan of care should be reviewed within seven days of the case manager's notification of the change. If the client was in an acute care facility, the plan of care should be reviewed within seven days of the case manager's notification of the client's return to his or her place of residence.

C. All periodic care plan reviews are subject to the Prior Authorization criteria found in section A of this chapter.

2 - 8 Periodic Review of the Level of Care (Recertification)

A. The waiver case manager must periodically conduct a comprehensive reassessment to document the client's current level of care and to assure that home and community-based waiver services remain a feasible alternative

to institutionalization and continue to meet the client's needs. The reassessment includes: reviewing physician's orders; reviewing the client's medical records and pertinent interdisciplinary evaluations; and providing an update of this information or documenting why an update is not necessary.

B. The waiver case manager must recertify the client's medical eligibility and need for continued waiver services. Recertification of the client's level of care must occur at least once a year (12 months from the client's entry into the waiver or within 12 months of the most recent level of care determination). Recertification must be completed within the calendar month in which it is due.

2 - 9 Termination or Reduction of Home and Community-Based Waiver Services

The case manager will provide the client or legal representative with written notice of termination or reduction in home and community-based waiver services and the client's right of appeal.

Reasons for terminating or reducing home and community-based waiver services are any of the following:

A. Death of the client;

B. Whereabouts of the client is unknown;

C. Client no longer meets the waiver level of care or targeting criteria;

D. Client moved out of the State of Utah;

E. Voluntary withdrawal of the client from the program;

F. Home and community-based waiver services are no longer a feasible option;

G. Change in financial status of the client;

H. Change in health or functional status of the client;

I. Client was placed in an institution, including a public institution.

2 - 10 Fair Hearings

Waiver applicants and clients will be given the opportunity for a hearing, upon written request, if:

A. They are determined ineligible for admission to the waiver;

B. They are determined eligible but not offered the choice of institutional care or community-based waiver services;

C. They are denied the home and community-based waiver services of their choice; or

D. They are denied the waiver provider(s) of their choice if more than one provider is available to render the service(s).

3 SCOPE OF SERVICE

Waiver clients are eligible to receive regular Medicaid program benefits such as private duty nursing services, pharmaceuticals, and medical equipment and supplies. **In addition, when necessary to prevent institutionalization and delivered pursuant to an approved plan of care, the following "waiver services" are available**:

- Case Management Services
- Respite Care
- In-Home Respiratory Care Service
- Nutritional Evaluation and In-Home-Based Treatment
- Portable Oxygen for Non-Medical Transportation and Activities
- In-Home Family Counseling

Details concerning coverage of these services are contained in the remainder of this chapter.

3 - 1 Case Management Services

A. Definition

Case management services assist waiver clients in gaining and coordinating access to necessary medical, social, educational and other services, regardless of the funding source for the services to which access is gained. (Refer to Chapter 2, *SERVICE AVAILABILITY*.)

Case managers are responsible for ongoing monitoring of the provision of services included in the client's plan of care. Additionally, case managers initiate and oversee the process of assessment and reassessment of client level of care and the development and review of plans of care.

B. Qualified Providers

Waiver case management services are provided by the Division of Community and Family Health Services. All individuals providing waiver case management services reimbursable by Medicaid must:

1. be employed by or under contract with the Division of Community and Family Health Services;
2. be licensed as a registered nurse, a clinical social worker or a certified social worker in accordance with Title 58, Occupational and Professional Licensing, Utah Code Annotated, 1953 as amended; and
3. have at least one year of work experience in the field of pediatric or child health services. ?

C. Reimbursement for Services

1. Case management services must be provided by a qualified provider as described above.

2. Case management services must be included in the client's approved plan of care.

3. Medicaid reimbursement for waiver case management is dictated by the nature of the activity and the purpose for which the activity was performed. When billed in reasonable amounts, given the needs and condition of the particular client, the following activities and services are covered by Medicaid under waiver case management:

    a. Assessing and documenting the client's need for community resources and services;

    b. Developing a written, individualized, coordinated plan of care to assure the client has adequate access to needed medical, social, educational and other related services with input as appropriate from the client, family, or legal representative, and other agencies and individuals knowledgeable about the client's needs;

    c. Linking the client with community resources and needed services, including establishing and maintaining eligibility for entitlements **other than Medicaid**.

    d. Coordinating the delivery of services to the client by encouraging the use of cost-effective medical care, and discouraging overutilization of costly services, such as emergency room care for routine procedures;

    e. Monitoring the quality and appropriateness of the services received, for the purpose of assisting the client to gain access to or maintain needed services;

    f. Instructing the client or caretaker, as appropriate, in independently obtaining access to services needed for the client;

    g. Periodically assessing the client's status and modifying the waiver case management service plan as needed; and

    h. Periodically monitoring the client's progress and continued need for waiver case management and other services;

4. The agency may bill Medicaid for the above activities **only if** the time spent by the case manager involves a face-to-face encounter, telephone or written communication with the client, family, caretaker, service provider, or other individual with a direct involvement in providing or assuring the client obtains the necessary services documented in the case management service plan.
5. In accordance with federal Medicaid guidelines, **the following are not considered waiver case management services and should not be billed to Medicaid as such:**

    a. Documenting waiver case management services is not reimbursable, with the exception of time spent developing written level of care certifications, needs assessment(s), and plan(s) of care as described in Chapter 2, *SERVICE AVAILABILITY*.

    b. Teaching, tutoring, training, instructing or educating the client or others (except in so far as the activity is specifically designed to assist the client, parent or caretaker to independently obtain needed services for the client) is not reimbursable. For example, assisting the client to complete a homework assignment or instructing a client or family member on nutrition, budgeting, cooking, parenting skills or other skills development is not reimbursable.

    c. Directly assisting with personal care or activities of daily living is not reimbursable. For example, directly assisting with budgeting, cooking, shopping, laundry, apartment hunting, moving residences or acting as a protective payee are not reimbursable activities.

    d. Performing routine services including courier services is not reimbursable. For example, running errands

or picking up and delivering application forms, food stamps or entitlement checks are not reimbursable activities.

e. Providing medical assistance services other than case management services is not reimbursable. For example, administering psychological evaluations, performing nursing examinations, or delivering treatment, therapy and counseling are not reimbursable under case management.

f. Traveling to the client's home or other location where a covered case management activity will occur is not reimbursable, nor is time spent transporting a client or a client's family member.

g. Providing services for or on behalf of other family members which do not directly assist the client to access needed services is not reimbursable. For example, counseling the client's sibling or helping a child's parent obtain marriage counseling are not reimbursable activities.

h. Performing activities necessary for the proper and efficient administration of the Medicaid State Plan, including assisting the client to establish and maintain Medicaid eligibility is not reimbursable. For example, locating, completing and delivering documents to the Medicaid eligibility worker is not reimbursable as a case management service, nor are recruitment activities in which the agency or case manager attempts to contact potential clients of service.

D. Procedure Code

Unit of Service	Procedure Code	Provider Type(s)
Per 15 Minutes	Y0015	46 - agency

3 - 2 Respite Care

A. Definition

Respite care is a service provided on behalf of an eligible client to relieve the primary care giver from the stress of providing continuous care, thereby avoiding the client's premature or unnecessary institutionalization. Respite care may be provided in the client's home and other approved community settings.

B. Qualified Providers

Qualified respite care providers include Medicaid enrolled, licensed home health agencies which:

1. employ or contract with registered nurses and licensed practical nurses (licensed in accordance with Title 58, Occupational and Professional Licensing, Utah Code Annotated, 1953 as amended) and home health aides (certified in accordance with Utah Administrative Code R432-700-22); and

2. are capable of providing respite care services to technology dependent, medically fragile individuals in their homes and other approved community-based settings.

C. Reimbursement for Services

Respite care services must be prior authorized by the case manager and be based on the individualized needs of the client and care giver. The case manager in conjunction with the primary care giver, physician, and other professionals involved in the care of the client will determine where respite care services will be provided, the qualifications of staff who will provide the care, and the number of hours of care that will be authorized based on need and established limits (refer to number 2. below).

1. Respite care services will be authorized in hourly units. No fewer than two hours of respite care will be authorized per episode.

2. Respite care will not be authorized in excess of 576 hours per client per waiver year. A client's waiver year begins on the first date of admission to the waiver and, thereafter, on his or her annual recertification date. Authorized respite care hours may be accrued during the waiver year, but accrued hours must be used prior to the end of the client's waiver year. Hours may not be carried over from one waiver year to the next.

D. Procedure Codes for Respite Care

Unit of Service	Procedure Code	Provider Type(s)
RN, per hour	Y0017	58 - Home Health Agency
LPN, per hour	Y0018	
Home Health Aide, per hour	Y0019	

3 - 3 In-Home Respiratory Care Service

A. Definition

In-home respiratory care is a short-term, specialized therapeutic service to help maximize the client's cardiopulmonary function through the application of professionally accepted techniques.

B. Qualified Providers

Qualified providers include Medicaid enrolled home health agencies which employ or contract with licensed respiratory care practitioners.

C. Reimbursement for Services

1. Respiratory care services must be prescribed by a physician;

2. Respiratory care services must be provided under the qualified medical direction or supervision of, a physician in accordance with Title 58, Chapter 57 of the Utah Code Annotated;

3. Respiratory care services must be prior authorized by the case manager. Services will be authorized on the basis of documented medical necessity when the client's need for respiratory care exceeds the level of service that is routinely performed by a registered nurse or a licensed practical nurse; and

4. Respiratory care services are limited to two visits per day by qualified providers.

D. Procedure Codes

Unit of Service	Procedure Code	Provider Type(s)
at 1 Visit, per Day	Y0023	58 - Home Health Agency
at 2 Visits, per Day	Y0024	

3 - 4 Nutritional Evaluation and In-Home-Based Treatment

Unit of Service	Procedure Code	Provider Type(s)
Nutritional Evaluation and In-Home Treatment, per session	Y0025	58 - Home Health Agency
Team member, In-Home Treatment		
Dietician, per visit	Y0026	
O. T., per visit	Y0027	
P. T., per visit	Y0028	
Speech Therapist, per visit	Y0029	

A. Definition

Nutritional evaluation and home-based treatment are specialized diagnostic and treatment services provided by an interdisciplinary team to enhance the ability of a client who cannot obtain adequate nutrition through ordinary means (oral intake of adequate food and nutritional substances).

1. Nutritional Evaluations

Nutritional *evaluations* (initial and semiannual as necessary) will be conducted by an interdisciplinary team that may include the following practitioners for the purposes stated:

a. **a certified dietician**; measures height and weight, records diet history, analyzes caloric and nutrient intake, calculates fat and muscle stores, and performs nutritional education for families.

b. **a licensed speech therapist**; especially for cleft lip and palate treatment to determine the best alternatives (e.g. surgery, appliances) to assist in promoting nutritional intake; evaluates speech related to oral/motor problems.

c. **a licensed occupational therapist**; evaluates oral/motor pathology, performs swallow studies, evaluates self-feeding skills and modification of equipment for self-feeding and home programming.

d. a **licensed physical therapist**; evaluates positioning necessary for safe feeding; adapts and modifies positioning equipment for feeding; can evaluate oral motor pathology and develop home programming.

2. In-home Treatment Services

Based on the team's assessment and recommendations, in-home *treatment services* may be provided by one of the practitioners listed in item 1 - Nutritional Evaluations.

3 - 5 Portable Oxygen for Non-Medical Transportation and Activities

A. Definition

Portable oxygen for uses that are not considered “medically necessary” under the regular Medicaid State Plan criteria may be reimbursed under the waiver as a cost-effective means of increasing the primary care giver's ability to provide continuous care while increasing the client's participation in normalized activities outside the home setting.

B. Qualified Providers

Qualified providers of nutritional evaluation and in-home-based treatment services include:

1. Medicaid enrolled home health agencies that employ or contract with licensed physical therapists, licensed occupational therapists licensed speech pathologists and certified dieticians; and
2. The State's Maternal and Client Health agency and agencies under contract with the Maternal and Client Health agency.

B. Qualified Providers

Providers must be medical suppliers enrolled with Medicaid.

C. Reimbursement for Services

C. Reimbursement for Services

1. Nutritional evaluation and in-home-based treatment services must be recommended by a physician.
2. The number of portable oxygen that will be authorized by the case manager will be based on the need of the client and primary care giver.

The number of portable oxygen that will be authorized by the case manager will be based on the need of the client and primary care giver in the client's plan of care. Services will be authorized on the basis of documented medical necessity.

D. Procedure Code

D. Procedure Codes

Unit of Service	Procedure Code	Provider Type(s)

Portable Oxygen Refill	Y0030	62 - medical supplier

3 - 6 In-Home Family Counseling

A. Definition

In-home family counseling is a service designed to benefit the waiver client by helping the client's family cope with the stress that accompanies the daily care required for a seriously ill client. Enabling family members to manage this stress improves the likelihood that the technology dependent, medically fragile client will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization.

This is a crisis or short term counseling service for the direct benefit of the waiver client. Family members who are suffering from a serious emotional or mental illness or disorder should be referred to an appropriate mental health care provider. Family members who are also eligible for Medicaid should be referred to a Medicaid mental health provider in accordance with the information printed on the Medicaid Identification Card.

B. Qualified Providers

Providers of in-home family counseling services include licensed clinical social workers, licensed certified social workers, licensed psychologists or licensed marriage and family therapists employed by, or under contract with, a licensed and enrolled home health agency or the State's Maternal and Child Health agency, and practicing within the scope of their license.

C. Reimbursement for Services

1. Family counseling services are authorized by the case manager on the basis of family need. Whenever possible, the provider must contact the case manager in advance of the counseling session to obtain authorization. If the provider delivers counseling services to a family in crisis, the provider must notify the case manager within one working day of the emergency to request authorization for payment of the service.

2. Family counseling services are limited to family members. Family members are defined as the persons who live with or directly provide care to the client, and may include a parent, spouse, children, relatives, foster family, or in-laws. Family members do not include individuals who are employed to care for the client.

D. Procedure Code

Unit of Service	Procedure Code	Provider Type(s)
Per Session	Y0031	46 - Agency and 58 - Home Health Agency

4 RECORD KEEPING

A. All home and community-based waiver service providers must develop and maintain written documentation for each billed service that indicates the following:

1. the name of the client;
2. the specific services rendered as they relate to the plan of care;
3. the date each service was rendered;
4. the amount of time it took to deliver the service(s);
5. the setting in which the services were rendered [e.g., home, office, etc.]; and
6. the qualified individual who rendered the services.

B. The record must be kept on file and made available as requested for State or Federal assessment purposes.

5 PROCEDURE CODES (SUMMARY)

The following list of procedure codes is a summary of codes covered by Medicaid under the Home and Community-based Waiver for Technology Dependent, Medically Fragile Individuals. All services are limited to the provider types noted for each procedure code.

CODE	DESCRIPTION	PROVIDER TYPE(s)
Y0015	Case Management, per 15 minutes	46 - Agency
	Respite Care, Community Based:	58 - Home Health Agency
Y0017	RN, per hour	
Y0018	LPN, per hour	
Y0019	Home Health Aide, per hour	
Y0023	In-Home Respiratory Care Service: at 1 visit, per day	58 - Home Health Agency
Y0024	In-Home Respiratory Care Service: at 2 visits, per day	58 - Home Health Agency
Y0025	Nutritional Evaluation, per session	46 - Agency and 58 - Home Health Agency
	Team member, In-Home Treatment	46 - Agency and 58 - Home Health Agency
Y0026	Dietician, per visit	
Y0027	O. T., per visit	
Y0028	P. T., per visit	
Y0029	Speech Therapist, per visit	
Y0030	Portable Oxygen for Non-Medical Transportation and Activities: Portable Oxygen Refill	62 - Medical Supplier
Y0031	In-Home Family Counseling, per session	46 - Agency and 58 - Home Health Agency